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AUTHOR	Christ, Jacob; And Others
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Abstract

Increasingly in the last decade, adolescent patients have come to the attention of psychiatrists, psychologists and social workers. Characteristically, when a teenager comes for help, he is in a state of crisis. After dealing for two years with adolescents in crisis, the Outpatient Clinic at McLean Hospital has learned to subdivide the great number of adolescents in crisis into meaningful types and categories. The main finding on clinical adolescent crisis is that families are intimately involved in the crisis; that there is family reinforcement. An adolescent in crisis also has to be distinguished from the chronically disturbed adolescent where the crisis is merely the visible peak of larger disturbance which had been hitherto clinically submerged. A four weeks limit is set on treatment of crisis situations. The use of a team approach and information gathering in three different settings is given by means of case examples. Treatment can be given in two ways, either by family treatment or individual treatment. Family therapy is more effective, since often the crisis is symptomatic of a larger family disturbance. (Author/KJ)

ADOLESCENTS IN CRISIS

Clinical Issues in their Treatment in an Outpatient Setting

from

McLean Hospital Outpatient Clinic

Belmont, Mass.

Authors: Jacob Christ, M.D.

Shirley Goldstein, M.S.S.

Marvin Snider, Ph.D.

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CLINICAL SIGNIFICANCE OF ADOLESCENT CRISIS IN OUTPATIENT CLINIC TREATMENT

Increasingly, in the last decade, adolescent patients have come to the attention of psychiatrists, psychologists and social workers. Characteristically, when a teenager comes for help, he is in a state of crisis. Something major is the matter with him and his world. His grades are declining, he is taking drugs, he has just been caught by the police for stealing a car; or if the teenager is a girl, she may just have returned from running away for the weekend, perhaps she has missed a menstrual period or even more urgently, attempted suicide. Teenagers, characteristically, more often than experiencing a change in themselves, have induced a change in their environment. Quite often parents, schools or legal authorities are the referral agents.

The Outpatient Clinic of McLean Hospital during the five years of its existence has been no exception. We too have received a great number of adolescent referrals and a preliminary survey of the first hundred cases of adolescents between 13 and 19 indicated that approximately fifty of them could be described as having been in a moderate or major crisis situation. It seemed reasonable to explore adolescent crisis precisely because of its clinical demands and also because the traditional methods of dealing with adolescents in outpatient clinics proved so woefully inadequate. After some two years of work with adolescents in crises, we can conclude in a general way that for one, we think we have found a reasonable method of dealing with adolescent crises. We also no longer look at adolescent crisis as a unitary syndrome, but have learned to subdivide the great number of adolescents in crisis into certain meaningful types and categories, and it is precisely this matter that is the main content of this paper, i.e. to bring to life for you the variety of adolescent crises and the variable clinical significance that the same syndrome, "Adolescent in Crisis", can have.

The currently available definitions of crisis contain both an aspect of equilibrium and development. So Gerald Caplan, for instance, defines crisis as a state of heightened anxiety residing within the person in which a change in balance or equilibrium produces disorganisation of the usual functioning of that person, and potentially offers the hope of reorganizing his personality at a more optimal level than existed previous to the crisis. Erik Erikson has described the life cycle as a successive dealing with characteristic crises and defined the adolescent psychosocial task as finding identity versus suffering from identity diffusion. Adolescence is seen as a more or less constant fluid state, and sometimes this is called a state of crisis. Peter Blos has further refined the developmental history of adolescence and has mapped out the stages of individuation that start with pre-puberty and continue until the identity crisis in late adolescence is resolved. In our study we have reserved the term crisis for acute clinical situations and have limited our concern to those adolescents who came with the history of some major change within the last six weeks. While in psychoanalytic psychology one may speak of a developmental crisis when certain maturational processes take place, a true clinical adolescent crisis may be a maturational crisis but usually is much more than that. Our contention is that the internal developmental crises of adolescence normally appear in a fashion in which family, school, physicians, peers or other caretakers can absorb the anxieties and cope with them. Much adolescent development takes place without the benefit of clinicians. In contrast, the acute crisis in adolescence which produces extreme conflict both within the adolescent and in his environment will bring adolescents and their families to the door of mental health facilities. We may say that the very fact of referral to a psychiatric facility will skew the adolescent clinic population towards the more pathological. In those cases, we had an opportunity to observe crises of major proportion going well beyond the developmental or maturational crises.

Our main finding on clinical adolescent crises is that families are intimately involved in adolescent crises, that there is a family reinforcement. It is often hardly possible to separate out who is in crisis; is it the adolescent or the parents or the family equilibium as a whole? Quite often the families are much more upset than the youngsters themselves, as for instance in the case of the 17-year old boy who was caught trafficking in marijuana, where the parents were rather excited and at the same time helpless, and the boy presented a rather stolid face which (only in time) we learned gradually to understand as reflecting a depression.

Perhaps we had learned this, for the main variable we were investigating was that of family reinforcement or, put in different terms, to what extent can this crisis be seen as residing within the adolescent himself and to what extent is the family either creating the crisis or contributing to it? Thus for instance, the family needs this youngster to express family conflict, as if the crisis becomes a call for help for everyone. We were trying to find out about these things by evaluating all adolescents and their families both individually and as total families. Crisis intervention of approximately four weeks duration was also carried out either by a form of family therapy or by individual methods. In the context we learned something about the differential effect that family-centered interventions have, as compared with the effect that individual interventions have. Among the symptoms that were presented, about half of the adolescents had run away for variable lengths of time, ranging from one night to two weeks. Other symptoms included destructiveness, provocative behavior, suicide attempts, severe depressions of a sudden onset, in two cases hallucinations and hysteric-like fugue states. Again, some findings were made while we were sorting out these various pathological features, both as to family context and to individual pathology. We had already

noted the relative scarcity of true developmental or maturational crises with no intervening family factors. Family reinforcement was practically always visible to some extent. We were somewhat less prepared to find out that a number of adolescent crises were in fact not crises but represented merely one incident in the life story of a chronic problem-adolescent. Some really psychotic youngsters came in a state of crisis, marked by depressive affect or hallucinations, some others came for a delinquent symptom, having had numerous prior episodes of delinquency. We had to learn to differentiate between the adolescent in crisis and the chronically disordered adolescent where the crisis is merely the visible peak of a much larger disturbance which had been hitherto clinically submerged. In cases of psychotic disorder or of chronic delinquency, a short-term crisis intervention is intrinsically unsatisfactory. Chronic disease presented as a crisis at a given moment does not make for successful crisis intervention. For delinquency, a more structured milieu may be necessary, in the case of psychosis hospitalization or long-term treatment may be in order.

Perhaps a few words are in order about the technique of crisis intervention. Some difficulty occurred around this issue early in our work. The question whether the clinicians really focussed on the crisis or in their customary way did psychotherapy was at first hard to resolve. Quite frequently our clinicians made recommendations for continued therapy and this suggested clearly that they did not consider their treatment completed once the four-week crisis intervention was over. Our team had to learn that it was possible to accomplish something in four weeks and, remarkably enough, our staff seemed to have a harder time accepting the four weeks' time limit than did the patients. The patients and their families were told at the start and practically all were able to accept this reality quite well. Only a few chose to continue after crisis intervention was over. Perhaps an example will clarify something more about the method and its usefulness.

Case Example:

The case of Sally may illustrate some of the ways in which crisis intervention took place. Sally, age 17, is the oldest of three girls. At the time of the crisis there was sickness in the family, as maternal grandmother was suffering from a carcinoma. The crisis itself came about when Sally ran away from home for three days after a scene with father during which she was slapped by him, a method of discipline which was not customary in this family.

She told the evaluating psychiatrist that she had friendships with boys, none of whom her parents approved of. The boys were of the leather-jacketted, rough variety, liked motorcycles etc., and Sally tended to feel excited about this. Father was out of the home most of the time, but she saw herself as like father who, incidentally, had also run away from home when he was a teenager. She and father shared an independence in their attitudes and she refused to be cuddled or soft in any way. She saw her mother as putting her on a pedestal. This served to keep her at a distance from mother but exposed her painfully to an awareness that she had palpitations in father's presence. She tended to depreciate some of her acceptable boyfriends who were on the dependent side, comparing them unfavorably with her father. We felt that Sally suffered from an unresolved dependence on mother, overcompensated by a premature attempt to emancipate herself in identification with a strong sexual father. The identification with father, as expressed in her running away, is one aspect of her relationship with him, but she also gets sexually excited in his presence.

A social caseworker saw Sally's parents together. It appeared that both father and mother had definite but quite separate points of view about Sally's behavior. Mother was gravely disappointed with her eldest daughter because she had not supported her in grieving for her own dying mother. Instead, Sally's younger

sister had taken this role. Sally merely wanted to be out of the house, and this made mother angry and disappointed in turn. Father, on the other hand, saw the problem as entirely a disciplinary one and felt that the issue could be settled by force and restrictions. In this joint interview, these parents began to share their perceptions and feelings about their daughter in a fairly open manner. The parents both heard each other for the first time and moreover, heard from the caseworker that there might be other ways of looking at the situation. We learned from this interview with the parents that mother had a desire to treat Sally like a baby; that she would have been very happy to nurse her, had she been sickly, but now she felt that her efforts were rebuffed by Sally who wanted to be independent and away from mother. We also learned that father indeed contemplated force as the main solution of the problems. He was completely oblivious of the sexual feeling he elicited in his daughter. Sally was able to see her interest in father, yet father was neither aware of her feelings for him nor of his own reactions.

The family interview, conducted shortly after the two initial interviews, revealed some additional circumstances. It showed that mother's grief reaction was more serious and clearly involved not only the loss of her mother but also the loss of her own feelings of being attractive due to her approaching the involutional period. It was also evident that Sally was not complying with the pressure that mother put on her to go through religious rituals which would have alleviated mother's suffering, by reassuring her that Sally held her in highest esteem. Sally, on her part, was pleading not for separation but for permission to be herself within the family setting, and this appeared to be the meaning of her running away. She came through as much more needful and dependent than she had shown herself previously; her main quest seemed to be that of self-expression. In addition, the family interview achieved a vital innovation in Sally's life.

It brought her face to face with father in a situation where they had to talk to each other. As it happened, they re-negotiated smoking privileges, but much more importantly, in doing so, Sally learned that things could be talked over safely with father. Father in turn became re-involved with his daughter whom he had relegated to mother after she became an adolescent at age 12. Emotional communication was thus re-established. Moreover, the relationship was clearly a father-daughter relationship, taking place in mother's presence, rather than a quasi-peer relationship which would carry with it the danger of sexualization.

This case illustrates some useful points. (1) We believe that we have found a method of observing crises in adolescents. A team approach which considers the individual adolescent, the parents and the family as a whole will yield fairly complete information on a given situation. (2) Quite regularly, the information gathered in the three different settings varies with each setting. Different dimensions of the problem are exhibited, and by bringing them together their connections become clear. In Sally's case, we learned something more and something different about the existing difficulties in each setting. In the individual interview with her psychiatrist she revealed her developmental snag which had to do with her need to flee from unresolved dependence on her mother. At the same time, she was intensely ambivalent about father whom she admired and identified with as strong and whom she chose as an exciting sexual object. The interview with the parents revealed mother's disappointment with her eldest daughter for not supporting her in her time of grief and father's complete oblivion to Sally's needs for affection and her sexual fantasies about him. Finally, the family interview, which provided a safe setting for re-negotiating a father-daughter relationship, proved Sally to be not so much desirous of separating as of wanting to have an identity of her own, separate from the one mother was defining for her. The involvement of family members in these settings was intense and all appeared to make good use of the therapeutic opportunities provided.

After a one-year follow-up, we can say that no further crises occurred of the nature that we first observed. Sally has settled down into the nest, so-to-speak and gotten along fairly well with her family. Perhaps it may become apparent from this example that the crisis is not necessarily residing in the adolescent. From the outset not only Sally but also her mother were in a state of crisis. As in Sally's example, so it happened in many others. The crisis appeared to be much more directly related to the family situation. A family can be described as in a state of equilibrium where there is some manageable balance between the needs of the family members and the resources that the family can bring to bear to meet those needs. Dis-equilibrium occurs when there are events which exceed the family's capacity to deal with the needs of one or more individuals or if resources of the family are depleted for some reason. The events of adolescence pose serious threats to the family equilibrium, as the increasing autonomy of the youngsters and their budding sexuality become dominant concerns to the parents. If parents allow those issues to come to the fore and somehow guide the adolescent into dealing with them, appropriate separation from the parents will eventually result and the adolescent will find himself able to make the transition from the parental home to new adult relationships.

An example of parents who were not able to deal with the stresses of an adolescent entering into sexual interests is the following:

A 16-year old girl ran away from home for approximately two weeks ostensibly to see a boyfriend. The family had instituted what might be called a chase during these two weeks, eventually leading to the capture of the young girl and her return home. The significant antecedents were that after the daughter had started dating, mother had suspected her of illicit exploits, ordered her to undress in her presence and accused her of having had sexual relations. It is of interest that mother at age 16 - coincidentally patient's age - had dropped out of school and run away to get married without her parents' permission. It appeared that

our 16-year old patient had been under considerable harassment from mother, which could be interpreted as an ambivalent challenge on mother's part for the daughter to run away like mother had done. Clearly, the mother's unresolved issues around illicit sexuality led her to relive her own life through her daughter. While she consciously criticized her, she unconsciously challenged her into elopement, premature marriage or illicit pregnancy. It was our speculation that had daughter succeeded in getting pregnant, mother would have showered her with all the maternal protectiveness she was capable of. The outcome of the crisis intervention in this case was more in the nature of a stalemate. A great deal of emotionality was vented, daughter dropped out of school and took a job, and in that sense she paid a price for regaining her acceptance from mother. The family as a whole dealt with the crisis quickly by blaming first the school and then the clinic. Yet the daughter recognized her incipient unsatisfactory identification with her manipulative mother and made a valiant effort to dissociate herself from it. Within one year - as we found out during the follow-up - she did not escape again, did not get prematurely married or pregnant and seemed so far to have allowed herself to develop, albeit according to the family's overt expectations. We will refer to her again later on. It seemed to us that while the parents, particularly mother, were unable to cope with daughter's sexuality, daughter was able to do somewhat better, but her development remained stifled.

Another family situation came to our attention, which is typical. A 14-year old boy came in because he broke furniture at home. In sessions both with the boy alone and with the family, it became abundantly clear that the boy had really very good reasons for breaking furniture at periodic intervals. Both his parents, who had problems of alcoholism, periodically argued with one another and threatened to break up the marriage. The boy's acting inevitably re-united the parents and in this way preserved the family equilibrium. Father himself occasionally had temper tantrums.

While we could not do justice to the situation, it appeared that a clarification of the meaning of the boy's delinquent pattern had a beneficial effect, particularly on the mother who was able to relax considerably and be much less provocative to her husband and her son. The onus of sickness, i.e. the focus of the crisis was no longer on the 14-year old boy but on the chaotic marital relationship where it properly belonged. In this situation, we were not dealing with a developmental crisis of an adolescent. There was, however, a chronic crisis in the parents' relationship, and the boy's pathology of breaking the furniture was really an attempt to remedy a much worse crisis, namely that of breaking up the marriage. In that sense, the boy's pathological behavior was adaptive and the maladaptation was in the interactional situation of the parents.

We believe that in many family therapies the issue of the parents' marriage is an important and often very painful one. The cases where an adolescent crisis bespeaks a more or less chronic state of dissatisfaction in the parents' marriage are the majority rather than the minority. We have observed in our study various states of alienation between parents ranging from the withdrawn and disinterested husband to the one who is intrusive, seductive or unable to assume an adult role. Among our mothers we found women who were infantile, withdrawn, psychotically depressed or simply not in contact with their feelings and those of their adolescent sons and daughters. Perhaps a large part of those parents were frightened of their own offspring and in several cases our main intervention was to strengthen the parents' hands, so they could deal better with their children.

We mentioned before that in our project we treated adolescent crisis in two different ways, either primarily by family treatment or primarily by individual treatment. While all cases were evaluated in the different settings outlined in Sally's case, and also re-evaluated in the same way after the crisis intervention, the main

intervention inbetween spelled the difference between two research groups. The question arises whether the results of treatment are different. While the final statistics are not in as yet, we have some tentative clinical impressions. They are not that one method is better than the other. In fact, both are good. We learned in differentiating family intervention from individual-centered intervention that each method accomplishes something different. There are considerable advantages in a family-centered method of sorting out the interpersonal problems. The pertinent issues between people become clear rather sooner than later. Better communication between parents and children and between spouses is almost invariably established. A unified pressure toward resolving the conflicts is created by the very "groupiness" inherent in the situation. This makes "getting over the crisis" the main agenda to be transacted. In the family interviews, many long-time secrets came out into the open. In one example, a father when speaking later of the first family interview, said it was a "bloody confrontation with family life". This bloody confrontation had opened the way for his children to make themselves heard and to remedy a crisis which had led his oldest daughter into a suicide attempt.

Our re-evaluations and follow-up interviews told us something about the effect of the individual crisis intervention. The case of the girl whose parents could not deal with her sexuality and who had to run away at sixteen, in identification with her mother, will have to be briefly discussed again. She was able to discuss her feelings of puzzlement about her mother in the confidentiality of individual interviews with her psychiatrist. At the end, she acknowledged that she was turning out to be somewhat like mother, strong-willed, volatile and with some gentle contempt for her male victims. She somewhat wistfully acknowledged that this was not really what she wanted. She recognized her potential for identifying with mother, yet did not really desire to do so. A similar wistful note came through

after about one year when she reported to the follow-up worker that she had not run away from home again, she was still working, she was not yet married, but she had indeed thought about running away on several occasions. She was still concerned with becoming someone in her own right rather than following mother's path. This girl, nevertheless, had safeguarded -probably because of her individual treatment- a view of herself as separate from her family, in the face of a situation which might have led almost inevitably to a strong identification with mother.

We might say then that in the short range and in clinical effectiveness family therapy is unsurpassed. A family confrontation leads quite naturally to better communication and the very fact that a whole group of people is concerned about a crisis is likely to bring it to a quicker solution and therewith re-establish family equilibrium. We feel, however, that there is a possibility of premature closure, leading to an inability of the youngster to separate himself from the family if the family sessions are not handled properly. We felt that in instances where individual contact became meaningful, the adolescent carried something more with him, namely an openness for further development which he might otherwise not achieve. We will have to substantiate these clinical impressions in a more exact way after all the data are compiled. We will also have to pay attention to the follow-ups which at this point are not available as yet.

We may summarize these few points about clinical significance of adolescent crisis. (1) While crises in the past have been frequently defined as developmental events within the adolescent, we believe that the immediate families are much more intimately involved in situations that can be properly labeled 'adolescent crisis'. We could demonstrate in a great number of our adolescent crises a direct relationship between problems within the family and the clinically perceptible adolescent

crisis. In many instances the marriage of the parents is disturbed or unsatisfactory.

(2) It is both possible and desirable to subdivide the clinical syndrome 'Adolescent in Crisis' into various categories.

(a) A category not really properly called 'Adolescent in Crisis' consists of many chronic diseases which at some point lead to a crisis in life. Chronic delinquency or a psychotic process may at one point rather dramatically become manifest and a crisis may ensue, involving the patient and the family. It is quite conceivable, in fact likely, that the chronically deprived, either socially, economically or emotionally are more likely to get into crises during adolescence. Our particular concern was for the acute crisis families rather than the chronically deprived.

(b) A characteristic developmental situation is given when parents are for one reason or another not able to handle the changes brought about by the growth and maturation of their offspring. Reliving of the past through the adolescent may take place, conflicts that the parents may have themselves will interfere with the effective dealing with problems of discipline and guidance.

(c) Problems quite unrelated to the adolescent, such as chronical marital conflict, may manifest themselves through the pathology of the adolescent. In fact, the adolescent crisis may be an attempt at restoring equilibrium by calling in help, albeit in a devious way. The adolescent in crisis is the symptom of a much larger family disturbance not centrally related to the adolescent per se.

(3) On a preliminary basis, it may be said that individual therapy allows an openness and fluidity of the situation for the individual adolescent which is often favorable to his development. Family confrontation and family-oriented crisis intervention has, by contrast, the immense advantage of clinical effectiveness with relatively rapid restitution of family equilibrium and the opportunity for improved communication. There is a natural pressure for quick resolution of the pathogenic issues in the family setting.

In summary, it seemed to us that the study of Adolescents in Crisis presents a highly rewarding and challenging new field of endeavor.

Jacob Christ, M.D.

Shirley Goldstein, M.S.S.

Marvin Snider, Ph.D.

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